

Amaanah Medical Practice

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Amaanah Medical Practice on 11 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good for providing services to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings across all the areas we inspected were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available for patients and easy to understand.

- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- Staff told us that they were able to share their views with senior management. They felt that there was a more open culture in place recently where staff were listened to and supported.

However there were areas of practice where the provider needs to make improvements.

The provider should:

- Continue to develop robust multidisciplinary arrangements with partners to ensure that patients with complex needs benefit from joined up care packages.
- Ensure that cervical screening and childhood immunisations carried out by the practice are monitored closely to provide positive outcomes for patients
- Ensure that staff are informed of the safeguarding lead at the practice

Summary of findings

- Ensure that staff have copies of minutes of all relevant meetings

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. Lessons were learned and processes were in place to communicate widely to support improvement. Staff recruitment systems were robust. There were enough staff to keep patients safe. Staff were knowledgeable about the risks to children and vulnerable adults and the action to take if they had any concerns.

Good



Are services effective?

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Staff had received training appropriate to their roles, however further training needs had recently been identified as part of a new appraisal process. Data showed that patient outcomes were below average for cervical screening and childhood immunisations and the practice were taking steps to address these outcomes.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice high for several aspects of care. Patients said they were treated with compassion, dignity and respect and mostly they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they generally they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Information about how to complain was available and easy to understand.

Good



Are services well-led?

The practice is rated as good for being well-led. Staff were clear about their responsibilities in relation to providing a good standard of care for patients. Staff told us they felt management support had improved. The practice had a number of policies and procedures to

Good



Summary of findings

govern activity. The practice had introduced a programme of meetings to strengthen their governance arrangements. There were systems in progress to monitor and improve quality. The practice proactively sought feedback from staff and patients, which it acted on. The practice acted on patient feedback and was in the process of setting up a patient participation group (PPG) at the time of the inspection.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 had a named responsible GP to manage their care.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had the lead role in chronic disease management. Patients at risk of hospital admission were identified as a priority and had longer appointments. Home visits were available when needed. Most of these patients had a separate phone number so that they could contact the practice directly and bypass the normal landline phone number. They also had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk of harm. Immunisation rates were below average for most standard childhood immunisations, however the practice was seen to be taking steps to address this. The practice was in the process of securing a permanent nurse position for the practice to ensure that the target for childhood immunisations was met.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Good



Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group. The practice offered an extended hours service for those patients who had work commitments. Each day the practice offered appointments up to 6.30pm and on two days per week was open until 7.30pm.

People whose circumstances may make them vulnerable **People whose circumstances may make them vulnerable**

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Practice staff identified patients with learning disabilities and treated them appropriately. The practice had begun to work with multi-disciplinary teams in the case management of vulnerable people. The practice informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients who experienced poor mental health had received an annual physical health check. The practice had a low prevalence figure for patients with dementia and was in the process of reviewing these patients.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) including those that may have been experiencing poor mental health.

Good



Summary of findings

What people who use the service say

We reviewed 43 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. Almost all comments received were positive about the service experienced. Patients said that staff treated them with dignity and respect and were kind and considerate. Two comments contained negative feedback which related to the difficulty in accessing the appointments system and having to wait for long periods to be seen by the GP.

We reviewed the most recent data available for the practice on patient satisfaction. This included

information from the national GP Patient Survey dated January 2015 which showed that 90% of patients who responded rated the practice as good or very good. The practice was also well above the local Clinical Commissioning Group (CCG) and national averages for its satisfaction scores on consultations with clinicians with 93% of practice respondents saying the GP was good at listening to them. The practice was in line with the local CCG average of 86% saying the GP gave them enough time.

Areas for improvement

Action the service **SHOULD** take to improve

Importantly the provider should:

- Continue to develop robust multidisciplinary arrangements with partners to ensure that patients with complex needs benefit from joined up care packages
- Ensure that cervical screening and childhood immunisations carried out by the practice are monitored closely to provide positive outcomes for patients

- Ensure that staff are informed of the safeguarding lead at the practice
- Ensure that staff have copies of minutes of all relevant meetings

Note: detailed actions will be written in detailed findings section of the report.

Amaanah Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor, a practice manager specialist advisor and an Expert by Experience who had personal experience of using primary medical services.

Background to Amaanah Medical Practice

Amaanah Medical Practice is located in Saltley a suburb of Birmingham in the West Midlands. The practice has four male GP partners, two female locum GPs, an interim practice manager, a practice nurse, a healthcare assistant and administrative and reception staff. There were 4,500 patients registered with the practice at the time of the inspection.

The practice is open from 8am to 7.30pm on Monday, Wednesday and Thursday and from 8am to 6.30pm on Tuesday and Friday. The practice is closed at weekends. Home visits are available for patients who are too ill to attend the practice for appointments. There is also an online service which allows patients to order repeat prescriptions and book appointments.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of clinics which includes asthma, diabetes and heart disease. The practice does not provide an out-of-hours service but has alternative arrangements in place for patients to be seen when the practice is closed.

Amaanah Medical Practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before our inspection of Amaanah Medical Practice we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Birmingham Cross City Clinical Commissioning Group (CCG) and NHS England area team to consider any information they held about the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 11 May 2015. During our inspection we spoke with a range of staff that

Detailed findings

included two GPs, the interim practice manager, a representative of the Patient Participation Group and nursing and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We spoke with eight patients who visited the practice during the inspection. We reviewed 43 comment cards where patients and members of the public shared their views and experiences of the practice.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?

- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff confirmed that there had been no near misses or medication errors reported recently.

We were told that the practice had been through a period of change during the last twelve months and staffing issues had impacted on the number of practice and clinical meetings held. However the interim practice manager showed us a detailed meeting schedule for the year and the agenda items which would be covered at each meeting. We saw that these included regular and ongoing monitoring of all safety incidents at practice meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events had not been a standing item on the practice meeting agenda, however we saw that significant events had been discussed at irregular practice meetings. The GPs and interim practice manager we spoke with confirmed that minutes of meetings where significant events had been discussed were not detailed previously. We saw that there had been improvements in relation to this. During and following the inspection, we were provided with copies of minutes of meetings which demonstrated that significant events had been given the priority required to ensure robust monitoring was in place. We were told that information from these events and other safety incidents were shared with the GPs and only passed onto other staff if appropriate for their role.

We saw evidence that the actions identified for learning or improvement as a result of individual significant events, had been completed. Staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We saw that national patient safety alerts were disseminated by one of the GPs to the most appropriate member of staff to action. However there was not a standardised process to ensure that each clinician responded to the alert in a consistent way.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were seen to be easily accessible for staff in the practice.

The practice had appointed a GP as the dedicated lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. For example we saw that all clinical staff at the practice had completed advanced safeguarding for children in 2014. We found that there were staff at the practice who did not know who was the dedicated lead for safeguarding. However they told us that they would speak to the interim practice manager or one of the GPs if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example vulnerable patients or children who may be at risk of harm. GPs used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The GPs were aware of vulnerable children and adults and records demonstrated good liaison with other health partners.

There was a chaperone information notice which was visible on the waiting room wall and in the consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional

Are services safe?

during a medical examination or procedure). We saw that the practice nurse had been trained to be a chaperone. Reception staff would act as a chaperone if the practice nurse was not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures which described the action to take in the event of a potential failure. However we found that one of the fridges in a consulting room did not have daily temperature checks and the practice policy had not been followed. The interim practice manager told us this would be addressed immediately.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the practice nurse had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Staff told us that when a prescription was ordered by patients who used high risk medicines, staff checked that the required blood tests had been completed and took appropriate action based on the results.

We saw that the practice had a prescribing policy. Staff were clear that all prescriptions should be reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

The practice was located in a single storey, purpose built medical centre which housed more than one practice. In the Amaanah Medical Centre reception area we saw that it was in need of refurbishment and the carpets were heavily

soiled. We saw that the seating provision for patients was basic and shabby. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Feedback in the patients' comments cards was also consistent with this and that they also found the practice to be clean and hygienic.

The practice had a lead GP and team responsible for infection control at the practice. This included another GP and a practice nurse who had undertaken further training to enable them to provide advice on the practice infection control policy to other staff within the practice.

We saw evidence that the interim practice manager had carried out an infection prevention and control audit on 1 April 2015 using a NHS template. The score from this assessment was seen to be 89% and actions put in place which included action to improve the reception area. We saw evidence that the interim practice manager had asked the lead for infection prevention and control at the CCG to carry out a review of the infection prevention and control systems at the practice. We saw that this was in progress.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and notices were seen in treatment rooms to enable staff to be clear about action to take in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid hand soap and hand towel dispensers were available in treatment rooms. We saw that disposable privacy curtains were provided in consulting rooms and treatment rooms to reduce the risk of cross infection and were last changed on 30 December 2014.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw a document 'Saltley Health Centre

Are services safe?

Legionellosis Management and Control Risk Assessment report' dated 16 September 2014 completed for the practice by NHS Property Services to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of 3 June 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example a pulse oximeter and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken for staff members prior to their employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We found that staff who carried out chaperone duties also had a DBS in place.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice premises were managed by NHS Property Services and their Centre Manager. The interim practice manager told us that they had a good working relationship with the Centre Manager. We were shown a fire risk assessment dated 10 December 2014 and

a fire drill / evacuation record dated 1 October 2014. We also saw evidence of checks on the building, fire equipment and emergency lighting last completed on 9 June 2014.

The GPs and interim practice manager told us that there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients and babies and young children. Patients were offered appointments that suited them, for example the same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews and contact was made to follow up on patients where they failed to attend.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure treatment room in the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis (a severe allergic reaction). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. Staff told us and we saw that these medicines had been checked monthly, however this had been increased to weekly from the beginning of May 2015. All the medicines we checked were in date and fit for use.

We saw that a business continuity plan had been developed and was in draft at the time of the inspection. This document highlighted a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and actions recorded to manage the risk. Risks identified included loss of computer system, loss of power and unplanned sickness. The document was seen to contain relevant contact details for staff to refer to. For example, contact details of an electrical company to contact if the power system failed. The interim practice

Are services safe?

manager confirmed that they were seeking approval from relevant staff to put their personal telephone details in the document in order for the document to have final sign off from the partners.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and practice nurse that we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Clinical Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and the practice nurse that they completed assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The practice nurse was responsible for the management of all chronic disease reviews in the practice such as diabetes, heart disease and asthma. Clinical staff we spoke with told us that they would like to have more opportunities to receive advice and support from the GPs in the practice. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG) and engaged in annual appraisal and other educational support. The annual appraisal process required GPs to demonstrate that they had kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us two clinical audits that had been undertaken in the last 12 months. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance to measure whether agreed standards are being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met. We saw that one of the audits was a completed audit of preconception counselling in patients with pre-existing type 1 and type 2 diabetes. Two follow up audits were carried out at a later date which showed that the action taken by the practice ensured that relevant patients had received the counselling to reduce any potential risks to them since the initial audit.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. Following the audits, the GPs shared their findings with relevant staff and looked at ways to make improvements where these had been identified. GPs maintained records showing how they had evaluated the service and documented the success of any changes. An example seen was of a second audit carried out by the practice in February 2015 to ensure that patients with heart disease were being prescribed an appropriate medicine in line with NICE guidelines. Evidence seen showed that the practice were prescribing correctly and information from the audit was shared with other GPs.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. In most areas the practice had reached performance levels that were higher than the national average. For example, the number of patients with diabetes who had received their

Are services effective?

(for example, treatment is effective)

flu injection was approximately 99% which was higher than the national average of approximately 93%. The practice had also achieved 97% for their total QOF points compared with a national average of 94%.

The interim practice manager and the GPs confirmed that an area for improvement for them was to maintain and record a schedule of meetings to demonstrate on-going performance monitoring and to share this information regularly with staff. The interim practice manager showed us that they had developed a meeting schedule which had commenced with a staff meeting on 30 April 2015. The meeting schedule set out a regular timetable of meetings to include clinical meetings, practice meetings and a monthly multidisciplinary team (MDT) meeting. We saw that a new agenda had also been developed for the practice meetings which included Health and Safety, Infection Control, Significant Events, Complaints, Safeguarding and QOF update. Following the inspection the practice sent us further evidence of practice meetings and minutes to support these.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicine alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had implemented the gold standards framework (GSF) for end of life care. It had a palliative care register and had introduced regular quarterly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff attended mandatory courses such as annual basic life support. We checked two GP staff files and found that both GPs were up to date with their yearly continuing professional development requirements. We saw that one GP had been revalidated and others were planned to take place over the next twelve months. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We saw that two of the GP records we looked at showed that they had completed certificates in diabetes care and the nurse had undertaken formal spirometer training.

The GPs and practice nurse performed clearly defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology for the practice nurse.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required. Staff told us that all results were dealt with daily and we saw evidence of this on the computer system. Staff spoke with understanding of their roles and felt the system in place worked well.

We saw that the practice had only had one multidisciplinary team (MDT) meeting prior to the inspection. The interim practice manager informed us that they had taken steps to address this and a programme of MDT meetings had been set up to take place quarterly. These meetings were to be held to discuss the needs of complex patients, for example those with end of life care needs or children at risk of abuse.

Information sharing

The practice had a system to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be

Are services effective?

(for example, treatment is effective)

shared in a secure and timely manner. Electronic systems were also in place for making referrals for patients through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We saw that the practice had a consent policy dated 1 April 2015 which included reference to the Mental Capacity Act 2005. All clinicians were aware of this Act and the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of this legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We

noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic medicine reviews.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and ensured that they were offered longer appointments for an annual physical health check.

The practice's performance for cervical screening uptake was lower than the national average, 74% compared to 82%. The practice told us that they had employed a nurse on a temporary basis to address this in addition to recruiting for a permanent practice nurse. They also informed us that they were in the process of developing an action plan to ensure that the targets were met. There was a policy to send reminders for patients who did not attend for cervical screening and the practice audited patients who do not attend. There was also an alert for this on the individual patient records.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was below average for the CCG; however there was a clear policy for following up non-attenders by the practice nurse.

The practice also offered NHS Health Checks to all its patients aged 40-75 years of age. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. Staff showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and described how they scheduled further investigations. We saw evidence that the practice had exceeded their target for completing NHS Health Checks in 2014/2015. We saw that out of 291 eligible patients, 217 had received a health check.

We saw that a range of health promotion leaflets were available in the reception area. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking cessation for example when they carried out routine checks with patients.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey January 2015 and the results of a patient satisfaction survey completed by one of the GPs to inform their annual appraisal in 2014. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 90% of patients who responded rated the practice as good or very good. The practice was also well above the local Clinical Commissioning Group (CCG) and national averages for its satisfaction scores on consultations with doctors with 93% of practice respondents saying the GP was good at listening to them. The practice was in line with the local CCG average of 86% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 43 completed cards and almost all were positive about the service experienced. Patients said that staff treated them with dignity and respect and were kind and considerate. Two comments contained negative feedback which related to the difficulty in accessing the appointments system and having to wait for long periods in reception to be seen by the GP. We also spoke with eight patients on the day of our inspection. Most comments were positive except for one patient who also had difficulty in getting through to the practice to make an appointment and five patients who said they had to wait too long to see the GP. We saw that the practice had taken action to address the issues in relation to waiting times to see their GP.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw

that patients observed the need for a 'privacy buffer zone' at the reception desk which enabled patients to have a potentially private conversation with staff and not be overheard. However we did not see a notice requesting this.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the interim practice manager. The interim practice manager told us that they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed patients had mixed responses to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 71% of practice respondents said the GP involved them in care decisions which was below the local CCG average of 80% and 91% felt the GP was good at explaining treatment and results which was above the local CCG average of 85%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. We also saw an example where the practice had arranged for an advocate to support an elderly patient who was refusing medication to ensure that their views were listened to.

Staff told us that translation services were available for patients who did not have English as a first language and staff knew the contact details of this service. We saw that the practice had a large number of patients from ethnic minority groups and the GPs told us that they were able to speak most of the languages used by these patients. This helped to support patients to understand the assessment process, any diagnosis given and their options for care and treatment.

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Feedback from patients showed that they were positive about the emotional support provided by the practice. For example, one patient wrote in the comment cards that they had received good support when they had been through some personal issues in the past. They told us that staff were caring, kind and supportive. Comments from other patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this feedback. Patients told us that staff were always ready to provide help and support when they needed it.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw that there was a limited amount of written information available for carers in the practice waiting area which helped them to understand the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, the GP signposted them to a support service for example the bereavement service at CRUSE or Birmingham Healthy Minds service. No patients that we spoke with on the day of the inspection had experienced a bereavement recently.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. National patient data showed that the number of patients in the over 65 years of age population group at the practice was approximately 3.6%, much lower than the national average of 16.7%. Similarly, the population group of patients over 75 years of age at the practice was 2% compared with the national average of 7.6%. However patients under the age of 18 years at the practice was 29.6% which was almost double the national average of 14.8%.

The practice provided a range of services to meet the needs of their patient population. For example, the practice had a palliative care register and we saw that regular meetings took place to support patients with palliative care needs and their families. We saw that patients with a long term condition such as asthma or diabetes were monitored and regularly checked at the practice. Staff told us that they offered support to these patients on how to manage their condition and gave them advice on healthy eating and smoking cessation.

Staff told us that patients who experienced poor mental health were signposted to a number of support groups. This included the Birmingham Healthy Minds service which is an NHS primary care psychological therapies service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and the practice had access to a telephone translation service for those patients who did not have English as their first language.

There were arrangements in place to ensure that care and treatment was provided for patients who may have mobility problems. The practice provided all services for patients on the ground floor. Access to the practice was via

an automatic door providing easy access for patients with wheelchairs or prams. We saw that patients who used wheelchairs or prams had enough room to move around the practice and had access to the treatment and consulting rooms. We saw that there were accessible toilet and baby changing facilities for patients use and parking available for patients with mobility restrictions.

We saw evidence that staff at the practice had received equality and diversity training. Staff we spoke with were knowledgeable and concerned about promoting equality and recognised the diverse needs of patients and the most appropriate way to meet those needs. There were also two female GP locums who worked regularly at the practice which enabled patients to have a choice of GP.

Access to the service

Appointments were available from 8am to 7.30pm on Monday, Wednesday and Thursday and from 8am to 6.30pm on Tuesday and Friday.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. The GP national patient survey dated January 2015 showed that 33% of patients who responded saw their preferred GP compared to a local CCG average of 58%. We saw that the practice had an action plan to improve this situation for patients. The practice's extended opening

Are services responsive to people's needs?

(for example, to feedback?)

hours on Monday, Wednesday and Thursday each week was particularly useful to patients with work commitments. This was confirmed by patient feedback received on the comments cards we received.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures dated 1 April 2015 were in line with recognised guidance and contractual obligations for GPs in England.

We saw that information was available to help patients understand the complaints system with details on how to make a complaint in a Complaints and Comments leaflet

and in the waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We saw that a complaints audit and quality check had been completed by the practice for the period January 2014 to March 2015. We found that this was well documented and highlighted the number of complaints received for the period (seven) and action taken in response to the complaints. This demonstrated that complaints had been handled satisfactorily, in a timely way with learning identified. The interim practice manager also showed us that they had developed a complaints register for April 2015 to March 2016 to ensure that any future complaints would be handled promptly and appropriate action taken.

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

We were given a copy of the draft Business Strategy dated 2015 – 2016 which we saw incorporated a detailed action plan. We saw that the vision was to aim to provide better access for patients and to provide timely appointments and access. Other aims included: contributing to the development of future potential for the community through engagement and initiatives, providing sufficient capacity and access, providing flexibility for patients and clinicians and nurturing a learning environment where education, training and learning becomes integral components of the work ethos. The interim practice manager informed us that the business strategy had been shared with staff and was on-going.

We also saw that the practice had developed a CQC compliance action plan. We saw that this plan was detailed and included actions for improvement, some of which had already been completed by staff.

As part of the business planning process, we saw that the practice was preparing to introduce a new IT system which would enable the practice to have a more detailed recording system and a more robust performance management system. The interim practice manager told us that this would be in place by October 2015 and training would be put in place for staff prior to its introduction.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and saw that they had been reviewed recently.

We saw that the practice had recently changed its management structure which was detailed in the business strategy with named members of staff in lead roles. For example there was a lead GP for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. All staff we asked told us that they felt supported by the interim practice manager who they felt involved them and listened to them. One member of staff said that previously they had not felt valued and supported.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The available QOF data

for this practice showed performance was generally above national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

One of the GPs attended monthly meetings with the local commissioning network (LCN) and had been involved in plans to transfer diabetic patients out of secondary care to be managed in the community. Appropriate training for GPs and nurses was planned to support this initiative.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example a fire risk assessment.

Leadership, openness and transparency

We saw from minutes that team meetings were held monthly from 1 April 2015. We were told that the practice had a number of staffing issues last year which impacted on the regularity of the meetings; however this had since been addressed. Minutes seen included specific tasks that staff must carry out. The interim practice manager told us that they would develop the meeting agendas to enable staff to contribute to the meetings and enable them to add agenda items prior to the meeting if they wished to. Two staff told us that previously they did not feel able to raise issues or suggestions for improvements to the service. They felt that there had been improvements recently and they felt more confident to raise issues and would be listened to.

The interim practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the Recruitment, Selection, Interview & Appointment Policy & Protocol and Recruitment Statement. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice gathered feedback from patients through patient surveys, suggestion cards and complaints received. We saw that the practice had taken action in response to patient feedback in the NHS England Patient Survey Results 2015-2016. The survey showed that 37% of patients who responded usually had to wait 15 minutes or less after their appointment which was much lower than the local Clinical Commissioning Group (CCG) average of 62%. Also

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

29% of patients who responded felt that they did not normally have to wait too long to be seen which was also much lower than the CCG average of 54%. We saw that the practice had developed an action plan in response to this and had identified three key areas for improvement. These were: ease of getting through to someone at the surgery on the phone, helpfulness of receptionists at the surgery and waiting times at the surgery. We saw that the practice had planned to discuss the action plan with the patient participation group in June 2015.

We saw that the practice had responded to negative comments made by a patient about the soiled carpets in the waiting area at the practice and the condition of the chairs used by patients. We saw evidence that the practice had made a formal request to NHS Property Services to address these issues. We also saw the most recent results from the Friends and Family survey and found that the majority of patients who responded were most likely to recommend the practice to others.

We were told that the practice had appointed a chair of the practice's new patient participation group (PPG). The PPG had been in place for a few months and the chair had been to other PPGs to observe their activities. We were told that no formal minutes of meetings with the chair had taken place as yet. The interim practice manager told us that the practice was in the process of setting up a virtual PPG. A virtual PPG is one that does not necessarily have to meet in person but can contribute via the internet and email suggestions and respond to any service development proposals made by the practice. It was envisaged that the PPG would include representatives from various population groups including patients of working age, retired patients and young patients.

The practice had gathered feedback from staff through staff meetings and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Some staff told us that they saw minutes of meetings however others said that did not have copies of meetings if they could not attend. The interim practice manager confirmed this had been identified as an issue and steps had already been taken to improve this. Minutes of meetings were available in the office.

The practice had a whistleblowing policy which was available to all staff in the practice and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that they would like to have more opportunities to maintain their clinical professional development through training and mentoring. They said that the new, interim practice manager was very supportive of training. We looked at five staff files and saw that pre appraisal forms had been completed but during the inspection, there was no evidence of any staff appraisals taking place. One staff member told us that they had spoken with the interim practice manager who had confirmed that their appraisal would take place in the next month and their training needs would be discussed there. Following the inspection we were sent evidence that staff appraisals had commenced and that they were involved in the process and training needs were identified.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients, however this needed to be formally recorded to demonstrate on-going improvement.